MEDICAL CARE PROBLEMS OF THE RESETTLEMENT ADMINISTRATION OF THE UNITED STATES DEPARTMENT OF AGRICULTURE

By R. C. Williams, B.S., M.D.
Medical Director - Resettlement Administration
Indianapolis, Indiana - May 29, 1937.

The Resettlement Administration, now a part of the United States Department of Agrilculture, was formed April 30, 1935 by an Executive Order signed by the President for the purpose of combining into one organization several agencies dealing with rural rehabilitation, land use and resettlement problems.

The Resettlement Administration activities fall into several main phases: first, the rehabilitation of low income and destitute farm families; second, land utilization concerned with land planning and the retirement and development of submarginal or substandard farming lands; third, the resettlement or relocation of farm families unable to gain a livelihood from their present locations; fourth, the development of three demonstrational, suburban communities for low income families.

Many of the families whose independence has been undermined by depression, drought, and dust storms have been given new opportunities. To such families the Resettlement Administration makes small loans ranging from $50 to $600. These loans carry interest at 5 percent and are secured by crop liens and mortgages on livestock. This money is used to rent land, and to buy farm equipment, livestock, fertilizer, seed, and the like.

To make sure that the borrower shall make the best use of his land, he is helped by an agricultural expert to work out an economical plan for managing his farm. He is urged to "l ve at home" as far as possible; that is, to raise more food and feed for his o n use and to depend less on a single cash crop.

Loans are also made to groups of farmers. For example, borrowers may

cooperate in the purchase of a thresher or other heavy equipment. Under this plan, each member of the group is able to use a piece of machinery which is too expensive for the individual farmer to buy. By means of such cooperative loans, groups of farmers are able to reduce their overhead operating expenses and consequently realize a greater income from their work and produce, thus overcoming their disadvantage in relation to large-scale operators.

If this system of rehabilitation were not in existence, the money now used for loans and grants would probably be spent on relief -- without providing a permanent remedy for the problem. As it is, this same money enables the farm family again to become self-sustaining.

The Resettlement Administration hopes to rehabilitate as many as possible of the destitute low-income and drought-stricken farm families, in order that they may again become a part of the social and economic life of the community. The standard program is to make loans to these farm families to attain this goal. These loans are being repaid. They are made under the direction of trained agricultural and home management supervisors. An applicant, to be eligible to receive this aid, must meet the following requirements:

(1) Inability to receive credit from any other source.

(2) To have received his last major income from farming.

(3) To have, or able to secure a farm on which to operate.

(4) To be in physical condition to do ordinary farm work.

(5) To be recommended by a local rehabilitation committee as appearing to have the necessary capacity and initiative to rehabilitate himself and the family on the farm. A typical committee consists of one or more leading farmers and farm women, a representative of the country official body, and representatives of business, professional, and civic groups.

The applicant who receives this credit must be able with the aid of the rural rehabilitation supervisors, to carry out a practical farm and home management plan.

The Resettlement Administration makes grants for direct relief to destitute and low-income farm families who cannot qualify for complete rehabilitation. In cases where families need immediate aid, direct grants are advanced. These grants are kept at a minimum and are designed to support the families until farm plans and loans can be arranged. Many require only temporary aid. The recent flood in the Ohio Valley is an example of the emergencies that may cause farm families to seek temporary assistance from the Resettlement Administration.

Clients, in order to repay their loans, must be kept in reasonably good physical condition. Provision for medical care is often an important and necessary part of the rehabilitation of a family.

From a medical standpoint there are, broadly speaking, two principal problems confronting the Resettlement Administration. The first is that of medical care for the destitute, drought-stricken or low-income farmers who are to be rehabilitated. The second relates to the sanitation of those groups who have been relocated, either in small community projects or on individual farms. The matter of medical care is the dominant problem. While the sanitation of the resettlement projects is important, the greater problem is making adequate medical care available to the destitute and low-income farm families who are being aided by the Resettlement Administration. These persons are living on farms scattered throughout practically every agricultural county in the United States.

The first step in providing this care was to approach the State Medical

Associations in those areas where our case load was heaviest or, for other reasons, where the need seemed most pressing, so that our problem might be explained and their cooperation and assistance obtained. With that in mind, negotiations were entered into several months ago with the State medical associations of certain of the mid-western States. It was found in all cases that the physicians with whom we had contact had no familiarity with the work of the Resettlement Administration or the problems that confronted us. Most of them had erroneous ideas that were based chiefly upon an article about the medical care program of the Resettlement Administration in North Dakota, which was printed in the Bulletin of the American Medical Association for October, 1936. After our problem had been explained, we requested assistance in working out a suitable plan for providing reasonably adequate medical care for the Resettlement Administration clients. The following plan, which was worked out for Indiana, was the result of a series of such conferences. This will give some idea of the principles that were evolved.

A PROGRAM FOR MEDICAL CARE FOR RESETTLEMENT CLIENTS IN INDIANA

The executive committee of the Indiana State Medical Association and the representatives of the Resettlement Administration suggest the following program to provide medical care for the clients of the Resettlement Administration in Indiana. An outline of the program suggested is as follows:

I. (a) That the County Medical Societies recommend to the physicians in their counties that they furnish to the Resettlement Administration clients and their families the services usually rendered by a family physician at such fees as the families are able to pay. This service will consist of home and office care, including obstetrical care and ordinary drugs. It will

not include major operations or hospitalization.

(b) A specified maximum fee for all surgical operations will be agreed to by representatives of the Resettlement Administration and each County Medical Society.

II. The Indiana State Medical Association will recommend:

(a) To the County Medical Societies that they urge the physicians to their counties to cooperate with the Resettlement Administration in the matter of providing medical care for their clients.

(b) That all questions concerning bills for medical services rendered under any program that is drawn up with the Resettlement Administration be referred to a committee of the local County Medical Society composed of the president, secretary and board of censors. If this committee cannot come to an agreement in regard to these bills with all parties concerned, the questions will then be referred to the Executive Committee of the Indiana State Medical Association.

(c) That the County Medical Society work with the County Rural Rehabilitation Supervisor and advise him of the physicians who have agreed to participate in this program.

III. The Resettlement Administration will:

(a) Have a representative, the local Rural Rehabilitation Supervisor, meet with the officers of the County Medical Society and bring to their attention the names of the Resettlement Administration clients in the county.

(b) The County Rural Rehabilitation Supervisor will advise the clients of the names of physicians who are willing to cooperate. The client will select the physician of his choice. The County Rural Rehabilitation Supervisor will then give to the client a memorandum for the physician showing that he is a client of the Resettlement Administration. The client and physician will then work out an agreement.

(c) The County Rural Rehabilitation Supervisor will then take an application for loans for the payment of the fee agreed upon. If the loan is approved, the Supervisor will so advise the physician. These funds will be made available for payments at such intervals as may be deemed advisable, payments to be made after the services have been rendered. The Rural Rehabilitation Supervisor will endeavor to secure funds either through grants or loans to take care of emergency surgical cases.

(d) The representatives of the Resettlement Administration, State and Regional, will work with the Indiana State Medical Association in this program, it being thoroughly understood by the Resettlement Administration representatives that such a program will be made available only to those low-income farm families who make up the Resettlement Administration case load.

We have found that in approaching the County Medical Societies we must go through the same process of informing them of our problem and motives that was necessary in our contact with the representatives of the State Medical Associations.

The above plan establishes several definite principles that are worthy of further consideration. A lump sum plan is adopted and the fee for service schedule is not used. It was with much misgiving that the physicians gave up the fee for service plan. When it was pointed out, however, that the persons for whom we were negotiating had, on an average, a total net annual income of from $50 to $300, it was realized by the physicians that these families would be unable to pay any considerable amount for medical care. It was thought that, roughly speaking, 10 percent of the cash net balance for each family would be a fair lump sum payment for medical care of that family. The average payment would be about $25 a year per family. This, of course, does not include hospitalization or surgical operations.

As yet, we have not accumulated sufficient experience upon which to base an opinion as to the practical working of this plan. Perhaps a year from now, we may be able to say more definitely what the difficulties and advantages are in such a plan. We hope to be able to obtain the assent of the State Medical Associations to try the plan in counties in a number of other States.

In the State of Washington, negotations are pending, looking toward a similar set-up based on six districts in the State. Each district will be composed of 5 or 6 counties. The lump sum for each Resettlement Administration family is to be worked out on an actuarial basis. This will consider the number in each family, their ages, and the expected net cash balance for the farm. In the city of Tacoma, a group of forward looking physicians has been studying the problem of medical care for several years. Through the assistance of this group, we will obtain assistance in working out these rates for farm families who are our clients in that State.

In our Resettlement projects, we are confronted with an entirely different

problem. These projects vary in size. Some of them have as many as 200 families in a group or project. Each house is usually placed upon a plot of ground that varies in size from one to four acres. A project consisting of 100 or more families may therefore be spread over an area considerably larger than the ordinary village. When these projects are located in inaccessible areas, the problem of medical care for the clients is often an acute one. In some instances, we have employed a local physician on a part-time basis. Wherever possible we employ a full-time community nurse on the Resettlement Administration payroll. Occasionally we find it necessary to employ a physician who gives his entire time to the project. We prefer to utilize the services of local physicians whenever possible, rather than to import a physician and employ him full time. In several communities the homesteaders have organized voluntary beneficial associations which serve as the agencies through which are worked out special agreements with physicians and hospitals.

In small projects that have less than fifty houses, the homesteaders are aided in working out plans for medical care. Such projects are closely integrated with the surrounding community, and any medical program must fit into the local medical picture.

In certain States of the west, particularly in North and South Dakota, there was a severe drought last year. In fact, the drought in 1936 was the fifth successive year of an unusually small amount of rainfall in these areas. As a result of this series of years of drought, there was practically a complete crop failure over both of these States, with the exception of a very small area along the eastern border of each. There were drought areas, of course, in other States, but North and South Dakota represented almost a state-wide

condition. During the summer and fall of 1936, in an effort to study the medical care aspects of the rehabilitation problem of North and South Dakota, a personal visit was made to these States and about 20 percent of the counties in each State were visited. It soon became apparent that, by reasons of the crop failure, the farmers there would be unable to provide subsistence for themselves and their livestock. This meant that they also had no money to provide medical care for themselves or their families. With the need for emergency medical care clearly indicated, a state-wide corporation was set up in North Dakota which had for its purpose the providing of emergency medical care to the destitute and drought-stricken farmers of North Dakota. This corporation receives from the Resettlement Administration loans or grants to be used in defraying the medical care bills of these farm families. Each client who receives medical care through this corporation executes a promissory note for the total amount of the bill. These services include home and office medical care, hospitalization, surgical procedures, emergency dental care, nursing and drugs when necessary.

Before setting up the corporation, the matter was thoroughly discussed with representatives of the North Dakota State Medical Association and the State Dental Association. They were fully aware of the destitute condition of the farm families in that State. The drought had rendered dependent about one-half of the farm families in North Dakota. There are approximately 85,000 farm families in the State, almost 45,000 farm families being dependent upon the Resettlement Administration for aid. During the latter part of the summer and fall of 1936, most of these people were taken care of by being given work in road building by WPA. As the winter weather came on and the road work ceased,

these families then came back to the Resettlement Administration as clients requiring subsistence grants. It is to such families that we give medical care through the North Dakota Farmers Mutual Aid Corporation. The general plan of operation of this Corporation is as follows:

A farmer who is a Resettlement client makes application for membership in the Corporation through the county representative of the Resettlement Administration. These County Rural Rehabilitation Supervisors are similar to county agents and have an agricultural background and training. After being granted membership in the Corporation, a client requiring medical care obtains authority for examination or such treatment as may be necessary from the county representative of the State Welfare Department, who has been designated as the representative of the Corporation in each county. Incidentally, I may say that, although this seems to put into the hands of non-medical persons the matter of making medical decisions, actually it works out the other way. The County Welfare representative gives authorization to the physician to examine the client or member of his family and to determine what medical attention is necessary. This really places the burden upon the physician who determines whether emergency medical care is needed.

"Emergency" medical care is deemed to refer only to such medical care as is necessary to treat acute illness or acute recurrences of chronic conditions, of such nature as to cause acute suffering, interfere with earning capacity, endanger life, or threaten some permanent new handicap that is preventable when medical care is sought; provided, however, that the term of "acute illness" shall include obstetrical care, and the authorization for obstetrical care shall include, where possible, an agreed minimum number of pre-natal visits, delivery in the

home or hospital, and necessary post-natal care. Dental care and treatment, as included in emergency medical care, shall, in general, be restricted to emergency extractions.

When the physician, dentist or hospital has rendered the service necessary, a bill is submitted to the Corporation through the County Welfare representative. These bills are audited in the central office of the Corporation at Bismarck by an experienced medical referee. We were fortunate in obtaining the services of an unusually competent and experienced physician for this purpose. He has been a resident of North Dakota for many years and has proved most helpful in preventing physicians from either consciously or unconsciously collecting unnecessarily large bills.

On the occasion of a recent visit to North Dakota, the operations of the North Dakota Farmers Mutual Aid Corporation were discussed with representatives of the Resettlement Administration, the medical profession and the clients. All were entirely pleased with the work of the Corporation. Throughout the State, the clients have a very kindly feeling toward the Resettlement Administration for providing this medical care during this period of emergency. Many of them have expressed their gratitude for this assistance. It is even surprising to note that some of them have paid in full notes which they signed sometime ago for this medical care. Where they obtained the money is difficult to imagine. Resettlement Administration officials in close touch with local matters in North Dakota feel that a very high percentage of the notes that have been given by these destitute and drought-stricken farmers will be paid this fall if there is a crop made in the State.

The physicians are, of course, obtaining pay for their services on a cash

basis, that is, the bills are paid within thirty to sixty days. There has been some delay in our payments because of a lack of clerical help. This is being remedied. The schedule of fees upon which we pay for these services is the one that was in effect between the State Board of Public Welfare and the State Medical Association. This represents a reduction of approximately 33 1/3 percent below the normal minimum fee schedule of the State Medical Association. It also embraces a flat maximum fee of $50 for any major surgical operation, and $15 or less for any minor surgical operation. The latest report which I have from North Dakota as to expenditures is as follows:

NORTH DAKOTA FARMERS MUTUAL AID CORPORATION
May 18, 1937

Members to date	23,808	
Authorizations for treatment received to date	9580..	$207,868.12
New Authorizations today	4..	151.51
Total Authorizations to date	9584..	208,019.63

It will be observed that to date we have treated 9584 cases, at a total cost of $208,019.63. This means that the cost per case has been approximately $21.70. The cost per family is $8.83. In making up our estimates for the work of the Corporation, we had considered that it would cost approximately $1.75 per person per annum. So far it seems that we are running slightly less than this. Although the Corporation in North Dakota was set up on October 8, 1936, it did not actually begin functioning until about November 1. The experience which we have had thus covers a period of approximately seven months.

The disbursements for the different types of medical care through April 30, 1937, in North Dakota have been as follows:

For Physicians' services 51.4%; for dental care 1.9%; for hospital care, 42.8%; for miscellaneous medicine, and drugs 3.9%.

The above recital of the problems of medical care that confront us in the Resettlement Administration is a record of actual experience and indicates the manner in which we have attempted to meet these problems that pressed for attention. By this time next year, we may be able to say with more definiteness what our results have been.

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This Plan Was Presented at a Meeting of the Southern Agricultural Workers
in Atlanta, Georgia - February 2, 1938

HEALTH AND MEDICAL CARE THROUGH PLANNED PROGRAMS

R. C. WILLIAMS, B.S., M.D.
Medical Director
Farm Security Administration
Washington, D. C.

During the past 30 years there has been a marked change in medical education in the United States. Educational requirements have been raised in an endeavor to furnish better trained physicians to serve the public. As a result, no person can now enter medical school who has had less than two years of college work. After completing the medical course, which requires 4 years, many graduates take as much as 4 or 5 years of interne or hospital training. This long, expensive and rigorous procedure to attain qualifications in medicin of necessity restricts the number of physicians who settle in the rural areas. Because of his training a recent medical graduate who enters practice is usually inclined to locate where hospital and laboratory facilities are available and where his opportunities for financial success are greater. As a result, most of the recent medical graduates locate in the larger cities or towns.

It is by no means unusual in the rural districts to find that the physicians in a given county are all more than 50 years of age and that none of them have been graduated during the past 25 years. This seeming concentration of physicians in the larger towns and cities is an important factor to consider when approaching the medical care problem in rural areas.

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The improvement of roads, the universal use of automobile, and improved methods of communication, have made it unnecessary for physicians to locate in strictly rural regions away from villages and towns. The

concentration of physicians in the larger towns and cities has a tendency to improve the quality of service rendered and to increase the use of the hospital and clinic facilities of a community.

There has been much discussion within the past few years relative to the problem of medical care for persons of the low income groups. The Farm Security Administration, realizing that economic rehabilitation in many instances is dependent upon physical rehabilitation, is endeavoring to work out programs of medical care for the low income farm families that it is endeavoring to rehabilitate.

In order that the work of the Farm Security Administration may be understood, the following brief statement of its activities is made:

The work of the Farm Security Administration falls into several main phases:

1. The rehabilitation of low income and destitute farm families.
2. The resettlement or re-location of farm families unable to make a livelihood from their present locations.
3. A program dealing with the problem of farm tenancy.
4. The development of three demonstrational suburban communities for low income families.

Many of the families whose independence has been undermined by depression, drought, crop failures and dust storms, have been given new opportunities. To such families the Farm Security Administration makes small loans ranging from $50 to $600. These loans carry interest at 5 per cent and are secured by crop liens and mortgages on livestock. This money is used to rent land, to buy farm equipment, livestock, fertilizer, seed, and the like.

Loans are made to groups - for example, borrowers may cooperate in

the purchase of a thresher or other heavy equipment. Under this plan each member of the group is able to use a piece of machinery which is too expensive for the individual farmer to buy.

The Farm Security Administration hopes to rehabilitate as many as possible of the destitute, low income and drought stricken farm families in order that they may again become a part of the social and economic life of the community. The standard program is to make loans to these families to attain this goal. These loans are being repaid. They are made under the direction of trained agricultural and home-management supervisors. An applicant to be eligible to receive assistance from the Farm Security Administration must meet the following requirements:

1. Inability to receive credit from any other source.
2. To have received his last major income from farming.
3. To have, or be able to secure, a farm on which to operate.
4. To be in physical condition to do ordinary farm work.
5. To be recommended by a local Rehabilitation Committee as appearing to have the necessary capacity and initiative to rehabilitate himself and his family on a farm.

   A typical Committee consists of one or more leading farmers and farm women, a representative of the county official body, and representatives of business, professional and civic groups.

The applicant who receives this credit must be able, with the aid of the rural rehabilitation supervisors, to carry out a practical farm-home management plan. Clients in order to re-pay their loans must be kept in reasonably good physical condition. Provision for medical care is often an important and necessary part of the rehabilitation of a family.

The method that we have endeavored to develop in working out plans for medical care for these low income farm families can best be described by taking one state as an illustration and discussing the plan that is actually in operation in that state. It is felt that the program for medical care

that is now in operation in the State of Arkansas is one which illustrates excellent cooperation between the organized medical profession and representatives of the Farm Security Administration in working out a plan that is mutually acceptable. There follows a copy of the Memorandum of Understanding between the Arkansas State Medical Society and the Farm Security Administration.

MEMORANDUM OF UNDERSTANDING BETWEEN THE OFFICERS AND MEMBERS OF THE ARKANSAS MEDICAL SOCIETY AND THE RESETTLEMENT ADMINISTRATION AND AFFECTED PARTIES

This is a statement of policy determined upon and recommended by the council of the Arkansas Medical Society and the Resettlement Administration in the matter of formation of medical cooperatives for farmers of low income who are clients of the Resettlement Administration in the State of Arkansas.

The clients of the Resettlement Administration are farm families living in rural areas of the State. Some of these families live on adjoining farms, on Resettlement projects, while the majority of them live on individual farms varying in distance from each other.

These families are citizens of the State with an agricultural background who have been approved as worthy of financial aid and assistance by committees composed of five leading citizens in each county. They are families who through several years of depression, misfortune or lack of good management, have exhausted all their personal means and financial security.

Small loans are being advanced by the Resettlement Administration to these families. The amount of the individual loan is based on the anticipated income of the family. A farm and home plan for each family is worked out through the cooperation of the family and the local representatives of the Resettlement Administration in each county.

By cooperative and more intelligent planning under the direction of trained agricultural leaders and with the necessary financial assistance, it is expected that these families may more reasonably and more comfortably live, repay the money borrowed from the United States Government, and become independent self-supporting families. It is recognized that medical service is one of the paramount needs of these families and that heretofore such services have been obtainable largely at the expense of the medical men serving the communities where they resided.

It is the desire of the Resettlement Administration that each of these families be provided adequate medical care and that the attending physicians be satisfactorily remunerated for their services.

It is also the desire of the Resettlement Administration to give full consideration to the principles of ethical practices and fair dealings proposed by the members of organized medicine. The Resettlement Administration pledges its best efforts to maintain for the client, the right to choose any legally authorized physician reasonably available and the right to discharge any physician with or without cause.

The Resettlement Administration will in all counties where there is an established medical society accept the dictations of that organized Medical Society in the distribution of such funds as are allotted for medical services, provided that the county medical organization will pledge themselves and their best efforts to give such medical services as these clients demand. In such counties who have no organized medical group, it is assumed they will be under the direction of the officer of the counselor district of which they are a part and such arrangement will be made with the authorized officers of that district on the same basis as is made with counties having organized medical societies.

In order that compensation may be made equitable, the officers and members of the Medical Society offer this policy: that all bills for services rendered in any stated area, be reviewed by an officer of the Medical Society, the fairness of the bill decided by him and authorized for payment on a percentage basis from the funds set apart as the cooperative funds for medical services as contemplated above. It is expected that all doctors will submit at the end of each month or after the performance of a stated service, their bills for services rendered, the amounts thereof to be determined according to the custom and usual professional charges in the community, all of which bills shall be submitted to the officer designated by the Society who shall review the same to determine its fairness and place the same in line for payment. At the end of the calendar month such bills as have been submitted, will be paid from the funds available for that month on a pro-rata basis. Should there be an amount due and payable the doctor over and above the amount paid, said amount shall be considered to have been paid in full and the accounts satisfied for that month. Should there be a residue in the fund after the payment of submitted bills for the calendar month, then such funds shall accrue to the succeeding month and shall thereafter be applied as bills are submitted therefor.

It is understood the physicians will render to the clients the same degree of care available to other patients in the county; that the attending physician will furnish all common drugs prescribed by him for cases of ordinary or common sickness.

It is further understood that a reasonable proportionate part of the available funds in each county, will be set aside to be used in paying for emergency antitoxins, major operations and hospitalization.

In case of grievances or over charge of accounts, full statement of the charges, if any, or complaints, shall be made to the reviewing official and shall be determined by him as to the equity and his ruling shall be final.

/s/ S. B. Hinkle
S. B. Hinkle, M.D.
Chairman of Advisory Committee

/s/ A. M. Rogers A. M. Rogers
State Director of
Rural Rehabilitation

As an administrative guide to the local supervisors of the Farm Security Administration, the following classification of counties with reference to their economic and crop production status was worked out:

GUIDE

For Making Loans to RR Clients for Cooperative Medical Services

AREA NUMBER ONE, $14.00 - $20.00

Rate: $12.00 plus $1.00 per person, not exceeding 8

Mississippi	Craighead	Jackson
Poinsett	Cross	Lawrence
Crittenden	St. Francis	Lonoke
Phillips	Lee	Jefferson
Desha	Monroe	Pulaski
Chicot	Woodruff	Arkansas
Prairie		

AREA NUMBER TWO, $12.00 - $18.00

Rate: $10.00 plus $1.00 per person, not exceeding 8

Clay	Hot Spring	Ouachita
Greene	Clark	Calhoun
Lincoln	Dallas	Lafayette
White	Cleveland	Miller
Independence	Union	Little River
Conway	Bradley	Nevada
Yell	Drew	Hempstead
Grant	Ashley	Pike
	Columbia	Howard

AREA NUMBER THREE, $10.00 - $16.00

Rate: $8.00 plus $1.00 per person, not exceeding 8

Faulkner	Marion	Cleburne
Pope	Boone	Van Buren
Sebastian	Carroll	Johnson
Logan	Madison	Franklin
Washington	Newton	Crawford
Sevier	Searcy	Scott
Randolph	Stone	Polk
Fulton	Izard	Montgomery
Baxter	Sharp	Garland
Benton	Saline	Perry

NOTE: This guide has been worked out and approved by the District Supervisors. Families of more than 8 persons will pay the same amount as a family of 8.

It is felt that the essential point in making plans for medical care is that the cost of such medical care be within the ability of the family to pay. This obviously will vary with the income of the family and their expected expenditures. The above listed classification of these counties and the sum set aside for medical care indicates the practical manner in which this principle is applied.

When it was pointed out that the persons for whom we were negotiating had on an average a total net cash annual income of from $10 to $150, it was realized by the physicians that these families would be unable to pay any considerable amount for medical care.

The above plan establishes some very definite principles worthy of consideration:

1. A lump sum is provided for medical care each month against which the physicians' customary professional fees are charged. While there may not be enough to pay all these fees in full each and every month, the physicians are assured of a reasonable percentage of collections at the end of the month for services rendered that month.

2. The family is privileged to call the physician of his choice within the community.

These funds in Arkansas that are set aside by each family for medical care are pooled in one sum in each county. The county medical society determines what amount of this sum is to be set aside for hospitalization and emergency surgery. The remaining amount is paid to the several physicians, the pooled fund being divided into twelve parts to be paid monthly in proportion to the total amount of fees for services rendered. Each family therefore sets aside and expends a definite amount for medical care for the year. In return for this they receive general practitioner care in the

home, including obstetrics and ordinary drugs. They are also provided with a limited amount of hospitalization and care during surgical emergencies.

In practice, a somewhat similar plan has worked very satisfactorily in 14 counties in Arkansas. We expect during the year 1938 that it will be in effect in perhaps 60 or more of the 75 counties in this State. 51 counties have already approved the plan. The rapid acceptance of the plan by both physicians and clients is good evidence of its practical value.

There are several points in the plan to which theoretical objection may be raised. One of these most frequently encountered is the fact that a family actually sets aside and spends from $12 to $20 for medical care per annum for which they may not receive any service, that is, in the event there is no illness in the family during the year. In actual practice in Arkansas, this has not proved to be a factor of any consequence. Most of the families receive some small amount of medical care and all of them feel that the security of the plan is well worth the investment that they make in it. This plan provides opportunity for preventive care as well as actual clinical work.

From the standpoint of the physicians, they are as well pleased as the families because most of the families had been unable to pay them anything in the past but are now able to pay something, although it may not be the full amount of the usual fee scheduled. The family increases its self-respect and feels that they are not objects of charity as regards medical care.

It is <u>not</u> to be understood that it is felt that the operation of the Arkansas plan is a final answer to all the problems of medical care in rural areas. It is, however, we feel, a successful example of what may be accomplished by planned cooperative effort.

The Medical Care Program for
Farm Security Administration Borrowers

(Digest of a paper presented at a meeting of the American Public Health Association by Dr. R. C. Williams, Chief Medical Officer)

The program under which more than 100,000 low-income farm families, borrowers from the Farm Security Administration, are at present obtaining medical care grew out of an economic necessity. It is an incidental by-product of a depression-born loan program for farm families unable to obtain credit elsewhere, and is designed to accommodate a special economic group only. The factors which created the program explain much of its organization and method.

I.

Five years ago, three million farm families were on the brink of disaster: flood and drought had played havoc with crops; dopression had brought economic chaos to an unstable farm economy; credit had vanished; crops were selling at low prices. It was a period of foreclosures and "penny" auctions. Farm families migrated from one rural area to another seeking an opportunity for livelihood that did not exist.

For roughly one-fourth of the farm population, relief was the only means of living until the Farm Security Administration offered to make small loans to enable farmers to get a new start.

The Farm Security Administration makes these loans, repayable within five years at 5 percent, so that farmers may buy the feed, seed and tools necessary for the year's operations. Often, the loans must help the farmer to meet the expenses of clothing and feeding his family until he makes a crop.

Before a farmer receives a loan:

1. He must be unable to obtain either funds or satisfactory credit from any other source, public or private.

2. He must know how to run a farm or have derived the major part of his income for the previous six months from farming.

3. He must be approved for the loan by a local county committee, generally composed of two or three farmers and one or two business men who can attest character and ability.

4. He must be able to do the farm work.

5. He must be renting a farm or have an equity in a farm.

All loans are based on adequate guidance of the family during the period in which they are trying to re-establish themselves.

Farm Security Administration supervisors work with the farmer until the loan is repaid, helping him to plan his farming operations and advising him on more effective methods of raising crops or conserving the soil. Home management supervisors periodically visit farm-wives and advise them on their problems of canning, raising gardens, sewing and other work affecting the success of the family enterprise.

From county supervisors, constantly in touch with borrower families, came the first inklings of a serious gap in the program's early efforts. Difficulty in working with some of the families was traced to acute illness, abscessed teeth, hernias, malaria and other conditions. It was reported that loans were defaulted as chickens, hogs, or calves were sold to pay for medical bills. When families had no money to pay for physicians' services, avoidable deaths occurred and the Government lost the money it had invested.

Typical of many reports, a western state showed that 75 percent of its borrower-families were on the rehabilitation program because of financial distress resulting from illness in the family. Financial statements of these families recorded liabilities from $100 to $3000 owing to physicians and hospitals over a long period.

An investigation of a sample of Farm Security Administration borrowers who had failed revealed that 50 percent of the "failure" cases were directly traceable to "bad health". Aside from the wanton waste of human life and curtailment of borrowers' usefulness to themselves, the findings of this survey indicated the need for some kind of medical care program from a purely economic point of view.

The basis of the medical care program is simply that a family in good health is a better credit risk than a family in bad health. Economic security depends, to a large extent, on health security. The Farm Security Administration loan program was in jeopardy until some feasible plan for getting medical aid to its borrowers could be found.

There was no organized system of providing medical care for medically indigent rural families in most of the states. It was not possible to make small supplemental loans to Farm Security Administration borrowers for medical assistance because of the cost and delay involved in making a loan, and the additional difficulties of auditing and individually justifying expenditures for medical care by borrowers. A single loan to each family at the beginning of the year to cover medical care for the twelve months was precarious since the incidence of disease among individuals is not exactly predictable.

The only feasible approach to the problem was the grouping of families paying a flat fee per year for medical care, under a plan to include physicians agreeing to treat them at a uniform fee schedule which would take into account the families' low income.

Two facts argued the acceptance of the plan: borrower-families realized they had desperate need for such a service and wanted one; physicians -- especially rural physicians -- were anxious to re-adjust a system of compensation which left them after a period of years with thousands of dollars worth of unpaid bills.

State Medical Associations were approached with tentative outlines for medical care plans. The plans were framed so that existing local facilities would be used in every case and participation fees would be based on the ability of the family to pay -- a principle long recognized by the American Medical Association and put into practice by the medical profession. Not all State Medical Associations have yet been approached -- the present program only started in the Spring of 1937 -- but already 27 State Associations have approved medical care plans.

Although local plans vary, in general, they follow three patterns. In most of the plans, borrower families pool their funds and put them in charge of a bonded trustee. The trustee then pays all physicians' bills for the group as fully as funds will allow, on a monthly, pro rata basis. Under another plan which is gradually being discontinued, funds are placed with a trustee, but separate accounts are kept for each family. The third kind of plan provides that an association of Farm Security families -- grouped together on projects -- may employ one or more physicians on a

salary basis to provide necessary medical aid, if there are no physicians living nearby.

Before any medical care plan is set up, a memorandum of understanding or a guide to be used as a basis for developing local health associations within the state is prepared by the State Medical Associations, with the help of Farm Security Administration officials. When these memoranda or resolutions are accepted by the State Medical Associations, agreements are then worked out with local medical societies.

The agreements with the county societies recognize three basic principles: 1) the participation fee for borrower families is determined by their ability to pay as indicated by their farm plans; 2) there is free choice of participating physicians; 3) funds are set aside at the beginning of the operating period in charge of a bonded trustee.

Benefits covered in the plan usually include: a) ordinary medical care, including examination, diagnosis and treatment in the home or in the office of the physician; b) obstetrical care; c) ordinary drugs; d) emergency surgery as determined by the physician in charge of the case; e) emergency hospitalization. Forward looking counties have added dental services. In Arkansas, 40 counties have plans for dental care which are operated on a separate basis from the medical care program. For $4.00 a year for the man and wife and $.50 for each child, the participating family obtains emergency dental treatment, simple fillings, extractions, prophylaxis and cleaning.

The family under the most typical agreement usually pays from $15 to $30 a year, the amount varying according to extent of benefits, size of average farm incomes in the locality, and size of family. A typical payment schedule for medical care in a low-income county might be on an annual basis of $18 for man and wife plus $1.00 for each child up to a maximum payment of $26 per family. From the pooled funds, a proportionate amount is allocated for hospitalization and emergency needs, including surgical care, at the beginning of each period. The remaining fund is then divided into equal monthly allotments.

Physicians submit monthly statements for services rendered to the trustee. Bills are then reviewed by a committee from the local medical society. If the total bills for a given month exceed the amount available, all bills are proportionately reduced and each physician paid his pro rata share of the month's funds. If the monthly funds are sufficient, the bills are paid in full; if a balance remains, it is carried forward to the next month or to the end of the period, and then used to complete paying bills for months in which funds were not adequate.

Under many of the county pool medical care plans, the patients are formally organized into unincorporated associations; others are informal groups with the trustee responsible for funds and the reviewing committee of physicians responsible for checking the bills.

The individual contract plan works on an entirely different basis. Funds for each participating family are kept separately and the physician of the family's choice agrees to render medical service for a certain sum a year. If the family has no illness that year, the money is refunded or

applied to the next year's account. If the family needs more services than are covered by the fee paid, the physician continues his services free of charge during the remainder of the period.

Experience with the two plans clearly indicates that for low-income families the first plan is preferable, that is, a plan providing for pooling of the individual fees. The individual contract plan is hard on the physician when a protracted illness develops and too often, families will avoid going to the physician in order to save the money they have set aside for medical purposes. Nor does the plan distribute the cost over many families, so that the cost of severe illness to one family can be more nearly equalized.

County or district plans for medical care are operating in 21 counties in Alabama, 68 in Arkansas, 4 in Colorado, 5 in Florida, 108 in Georgia, 5 in Indiana, 1 in Idaho, 3 in Iowa, 35 in Kansas, 7 in Louisiana, 41 in Mississippi, 12 in Missouri, 6 in Nebraska, 1 in New Jersey, 12 in New Mexico, 11 in North Carolina, 11 in Ohio, 25 in Oklahoma, 17 in South Carolina, 7 in Tennessee, 43 in Texas, 1 in Utah, 14 in Vermont, 19 in Virginia, and 3 in Wyoming. The swift extension of the program during the last two years is indicated by the increase in Georgia from 5 counties having medical plans last year to 108 counties this year.

Agreements with the State Medical Associations prior to approaching county medical societies have been reached with Kentucky, New York, Pennsylvania, South Dakota, West Virginia, and Wisconsin.

The financial report of a typical county group health association will demonstrate how the program works. The association whose report is given below, was sponsored by the Farm Security Administration but is now conducted by borrower families. It is operating in a Southern county in which more than 300 farm families are Farm Security Administration borrowers; 307 families are members of the association, paying an average of approximately $27 a year. The financial report for 1938 follows:

Financial Report for the Year 1938

Membership fees: 307 members @ average fee - $27.15--$8,334.00

	Medical Fund $5,278.20 - 63.3% Monthly allotment $439.85			Hospital Fund $2,639.10 - 31.7% Monthly allotment $289.92		
	Bills Presented	Bills Paid	Percent Payment	Bills Presented	Bills Paid	Percent Payment
Jan.	$427.13	$427.13	100%	$ 10.00	$ 10.00	100%
Feb.	671.03	439.85	66%	251.00	219.92	88%
March	516.59	439.85	86%	79.00	79.00	100%
April	649.91	439.85	68%	296.00	219.92	74%
May	492.40	439.85	89%	188.50	188.50	100%
June	599.23	439.85	74%	327.50	219.92	67%
July	825.30	439.85	53%	192.50	192.50	100%
Aug.	612.97	439.85	72%	224.50	219.93	98%
Sept.	521.88	439.85	84%	200.00	200.00	100%
Oct.	617.40	439.85	71%	378.50	219.93	58%
Nov.	493.95	439.85	89%	190.00	190.00	100%
Dec.	827.49	439.85	53%	276.00	219.93	80%
ANNUAL DISTRIBUTION OF SURPLUS						
Accumulated balances		12.72			433.95	
Hospital fund s'plus		25.60				
Admin. surplus		76.07				
TOTALS	$7,255.28	$5,379.87	74%	$2,613.50	$2,613.50	100%

ADMINISTRATION

$416.70 - - 5%

Salaries	$172.50	Postage	$24.00
Supplies	73.13	Bond Premium	37.50
Equipment	33.50	To Medical Fund	76.07

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No. of family members	307
No. of persons	1,653
No. of families having one or more persons receiving medical care	291
No. of persons receiving medical care	913
Per cent of families having one or more persons receiving med. care	95
Per cent of persons receiving medical care	55
No. of persons receiving hospitalization, or surgery, or both	78
Home visits	918
Office calls	1,717
No. of physicians participating	16

*Bills incurred	TOTAL	$9,868.78
	Medical Service	7,255.28
	Hospital Services	2,613.50
	Aver. bill incurred per member family	32.16
	Aver. medical bill per person receiving medical care	7.95
	Aver. Hospital bill per person receiving hospitalization (and surgery)	33.51

*Bills were presented for medical and hospital care and surgery on the basis of a fee schedule which was reduced 25% or more from regular fee rates.

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II.

There is a somewhat different approach to the problem of medical care in homestead projects established by the Farm Security Administration. In most of these communities, from 100 to 200 families have settled on adjoining farms. When these projects are located some distance from cities, the problem of medical care for the homesteaders is often an acute one. In a few instances, a neighboring physician has been employed on a part-time

basis. Occasionally, it has been necessary to attract a resident physician to the project, by setting up a program providing a basic guaranteed income. In most cases, however, the services of all nearby physicians are utilized. Medical care programs have been organized on 32 projects, and programs are now being set up on 10 other projects.

A wide variety of arrangements for medical care are in effect in these community projects. In several communities the homesteaders have themselves organized voluntary beneficial associations which have worked out special agreements with physicians and hospitals. On some projects, the families pay regular membership dues in cash, without help from the Farm Security Administration; on other projects the Farm Security Administration loans money to the homesteaders for this purpose, and these are later repaid when the crops are sold.

A few facts regarding a typical project program will illustrate how the medical needs of the homesteaders are being met. The 141 families on Ashwood Plantation, South Carolina, for example, became members of the health association by paying in advance $18 per family for general practitioner care for one year. All five physicians living nearby participated, agreeing upon a uniform fee schedule which represented a moderate reduction in their usual fees. An average of 83.5% payment was made on medical bills throughout the first year, the monthly payments ranging from 64.5 to 100 per cent.

Members of 96 percent of the families received service during the year, and 47 percent received service which exceeded the cost of the $18 membership fee.

At the beginning of the second year, the association added hospitalization for 21 days for each individual and specialist care for acute illness for an increased cost of $12 per family. A preliminary report indicated that in the first half of the second year 20 hospital cases were handled and that hospital and specialists' bills were paid 100 percent.

III.

Distinct and separate from the general program of medical care is the specialized program set up in North and South Dakota and in California and Arizona. These four states had local problems which made necessary a completely different type of plan. North and South Dakota had been seriously affected by the drought; California and Arizona experienced an influx of migrants whose highly unsanitary living conditions were a potential threat to the health of nearby communities.

North and South Dakota first tried a medical care program in 1936. In these two states alone, about 55,000 families were participating in a state-wide medical plan by November 1, 1938. By paying $2 a month per family for a minimum period of six months, families became members of the North Dakota Farmers' Mutual Aid Corporation or the South Dakota Farmers' Aid Corporation. Through these corporations they were entitled to emergency medical care, emergency dental care, emergency hospitalization, prescribed drugs and home nursing. Members had the free choice of any phisician licensed to practice medicine in the state. The charges made for medical service were based on a special schedule of fees agreed to by participating doctors and other professional men. Bills were paid monthly and pro-rated if funds did not cover the full amount of the bills.

With the advent of the more general program of medical care and the experience gained from it, certain flaws were noted in the Dakota plans. Both families and physicians seemed discontented -- the families maintaining that they did not receive enough services, the physicians stating that they did not receive adequate compensation for services rendered. In South Dakota, there was the additional factor of practitioners other than legally qualified doctors of medicine seeking to participate in the medical care plan.

The uncertainty of whether funds necessary to continue the program would be available caused additional uneasiness about the plans. The program in the Dakotas was declared inoperative as of July 1, 1939, pending reorganization.

At present, North Dakota has no medical care plan, although a tentative outline of proposed action has been submitted to the State Medical Association. This outline includes a higher fee of $33 per family a year to include emergency medical and dental care, emergency hospitalization and prescribed drugs.

The medical care program would be set up on a unit basis covering one or more counties, and funds would be kept separate for each area, thus leaving virtual control of the plan with the families and professional groups in the district. In effect, the proposal would put into operation in North Dakota local medical care plans similar to those existing in other states. The actual operation of the plan is pending its acceptance by the physicians of the state.

In South Dakota, a district plan is being set up on a trial basis at Pierre. This unit will provide medical care for Farm Security Administration families in several counties, having a potential case load of approximately 2,500 families or 12,500 persons. In this area, there are 13 physicians, 8 dentists, and 2 hospitals. Funds for participation will be loaned to these families on the basis of $33 a year per family to provide emergency medical and dental care, hospitalization and prescribed drugs.

No other units will be established in South Dakota until the unit at Pierre has proved effective.

In California and Arizona, a different type of medical care program was undertaken, to meet the needs of migratory agricultural workers who required medical attention, but rarely could afford to pay for such aid.

The influx of migrants into California and Arizona since 1935 has created a serious public health problem in these two states. Most of them have a low and uncertain income, live in roadside "jungles", patched tents or hastily-improvised shelters with no sanitary facilities.

The constant movement of migrants from one farming area to another, sometimes more than 300 miles away, contributed to the rapid spread of communicable diseases. Despite the vigilance of the California State Department of Health, outbreaks of smallpox or typhoid in widely separated counties remained a potential threat.

In May, 1938, the Farm Security Administration, with the cooperation of the California Medical Association, the State Department of Health and the State Relief Administration, formed the Agricultural Workers' Health and Medical Association, incorporated under state laws. Each of the agencies

has a representative on the Board of Directors of this non-profit association.

Migrants make applications for medical treatment at the association's district offices or camp treatment centers. A certificate of membership in the health association, which serves as an identification card, is issued to the applicant.

He then selects his physician from a list of participating physicians or is treated by the local part-time physician in charge of the treatment center. The Agricultural Workers' Health and Medical Association is billed for the medical services or hospital services rendered. In many treatment centers, local physicians work in the clinics at designated hours on alternate days. The personnel of the typical treatment centers consists of a part-time physician, a nurse, and a clerk. Services include ordinary medical care, surgery, laboratory, X-ray, dentistry, prescriptions, and diagnostic treatment.

Although the migrant-workers are obligated to repay the cost of services "if so requested" their economic status precludes any expectation of repayment in most cases. Some workers, however, have been able to repay a few dollars. In view of the savings effected in the health of the two states under this program, it seems probable that adequate financial support will continue. Similar conditions prevailed in Arizona, and similar measures were undertaken.

There are at present 13 medical care centers in California, at Fresno, Merced, San Joaquin, Tulare, Madera, Yuba, Yolo, Riverside, Santa Clara, Sonoma, Imperial, Kern and Calipatria, and 7 in Arizona - at Phoenix, Buckeye,

Avondale, Chandler, Yuma, Coolidge and Safford.

Appraisal of the medical care program is difficult. There are many pitfalls that have been avoided and yet, there are bound to be difficulties in a program which affects so many people in widely diverse areas. The human element cannot be overlooked. No matter how perfect a plan is theoretically, when put into practice it must deal with actualities. A reviewing committee, drawn from the physicians' ranks, is set up under each plan to go over bills. This committee can adjust bills when necessary. A strong reviewing committee limits abuses by the physicians. The county supervisor acts in a like capacity for the families, checking on the number of unusual demands for service made by families. Usually, if the family is abusing the program the matter can be adjusted satisfactorily, otherwise the family is dropped from the program.

The attitude of both the physicians and families toward the medical care program is, on the whole, favorable. Payments to physicians average, the country over, approximately 60 percent of total bills presented, which many physicians have reported is a higher percentage of payment than they receive from their ordinary practice in these areas.

The heart of the program lies in a clear understanding on the part of physicians and families as to what can be expected under the program and its limitations. It is essentially a special program for an under-privileged group of farm people. The program could not be transferred to any other segment of the population without some change. A more solvent group of people would demand an extended and fuller program of medical care.

Nevertheless, for the group of people whom the program is helping to

get back on their feet, the plan is a boon.

In the final analysis, the fact that 99 percent of the medical plans in operation last year are continuing to operate is a telling point, since the whole basis of the medical care plans is voluntary cooperation from families and physicians.

November 1, 1939
Figures as of September 30, 1939

UNITED STATES DEPARTMENT OF AGRICULTURE
Washington, D.C.

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For Nov. 18 P.M. Papers :
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BETTER HEALTH FOR NATIONAL DEFENSE

Speech by Dr. R. C. Williams, Chief Medical Officer of the Farm Security Administration, before the National Conference of Catholic Charities, 11 A.M., November 18, 1940, at Chicago, Ill.

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It appears that there is at least one virtue in the present world crisis. It is throwing a clear, strong light on many of the things that we have always taken for granted. Now that danger threatens us, we are taking stock of what this country of ours means in terms of freedom and welfare of the people. We are realizing, as we never did before, that we are all in the same boat. And we are beginning to enlarge the implications of security and health to include all the people.

We are not at war. But the threat of total war necessitates the concept of total defense—a total national effort to make this nation strong. If our defense efforts fail to take into consideration the man on the street or the man on the farm, all our planes and battleships will not help us.

Long before there was any talk of defense, the Farm Security Administration was carrying out a program which is basic to our defense efforts. Its job was to help disadvantaged farm families to regain a foundation of security on the land, families to whom the depression had brought disaster.

These farm families once had no stake in the country. They were as badly off as those farmers in ancient times who did not resist the barbarians' advance

on Rome. When the Barbarians asked, "Which way is the road to Rome?" these farmers who were working somebody else's land for starvation wages pointed to the road which led to the proud capital. "Take it, if you want to," they said. "It's nothing to us."

Only a few years ago we had more than a million and a half farm families trying to exist on an average income of less than $500 a year. For these persons, upwards of eight million of them, there was an average income of about $2.00 a week each. Under such a standard of living, many thousands of our farm people and their children went hungry. Their health and sanitary standards were almost unbelievably bad.

Fortunately a way has been found to help this part of our farm population climb back on the road toward health and security. To the poorer farm families — those overburdened with debt, working eroded soil and fighting against low market prices — the Farm Security Administration is making small loans, averaging about $300 per family per year.

To receive a rehabilitation loan, a farmer must be unable to obtain satisfactory credit from any other source, public or private; he must have farming experience, be able to run a farm, and must be located on a farm at the time the loan is made. He must also be physically able to do farm work. Finally, a county committee of local farmers must vouch for his character and ability.

These loans have helped more than 800,000 farm families to stay off relief. Instead, they have purchased a much needed mule or plow, a pressure cooker, seed, and sometimes food and clothing for the family. Guidance in home and farm planning came with each loan to insure the success of the borrower. These families, saved from the relief rolls, have gone on with their farming with the help of technically-trained supervisors.

Each year, farmers on the rehabilitation program outline their farm plans with the help of county supervisors. Instead of raising only one cash crop, the farmer raises two or three to minimize crop failure. He grows feed for his livestock, plants a garden to supply his family with fruits and vegetables, and follows soil improving practices suggested by the supervisor.

At the same time, home supervisors teach farm wives to use pressure cookers, so that home-grown vegetables can be canned; help them to make over old clothing to prevent inroads on the family's slim budget, or show them how to make attractive furniture out of any material at hand -- orange crates, old automobile seats or packing boxes.

This live-at-home program is beginning to do away with the conditions described in a report to the President five years ago:

> "The extreme poverty of one-fifth to one-fourth of the farm population reflects itself in a standard of living below any level of decency. Large families of tenants or croppers or hired farm laborers are living in houses of two or three rooms. Many have even no outside toilet, or, if one is available, it is highly unsanitary. Many of these families are chronically undernourished. They are readily subject to diseases * * * *. Clothing is often scarcely sufficient to afford protection to the body, much less maintain self-respect."

If a visit should be made to any one of the 800,000 farm families on the rehabilitation program today, you would not find a newly-painted house in every case, but you would find screens gradually replacing gunny-sacks in the windows, wells being protected, and sanitary privies being built. Inside the home you would find rows of shelves crowded with jars of beets, carrots, squash, spinach, peaches, pears, and apples -- insurance against the lack of vegetables in winter. There would be a farm and home record book within the home where the farmer and his wife keep track of the amount they spend for food, clothing, medical care, the church, and various other expenditures that make up their daily living.

It is encouraging to see how many of these farm families, once on or near relief, have made good. But on the other side of the ledger, we found families who, through no fault of their own, were falling back on their payments. Many of these families were disheartened and discouraged. We found that back of a significant number of these failures was bad health. Sometimes an infected tooth, a hernia, pellagra, or hookworm disease spelled the difference between success and failure of the farm family.

Recently a questionnaire sent to all rehabilitation families in Texas and Oklahoma illuminated the need for medical attention. About 43,000 families reported that one out of every three births for the year had not been attended by a physician. Of the 16,000 cases of serious illness reported for the year, more than half, or 8,456 lacked physicians' care. The total amount of unpaid doctors' bills was close to a half a million dollars.

Obviously, rehabilitation was only scratching the surface if it did not take into account the health conditions of borrower-families. To plug the leak in its rehabilitation efforts, the Farm Security Administration finally embarked on a medical care program.

With the cooperation of the organized medical profession, a voluntary group medical care plan was worked out for borrower-families. The plans developed to fit the situation, work on three simple principles: (1) families have free choice of physician; (2) the amount paid by the families for participation is based on their ability to pay; and (3) the money paid in by individual families is pooled into a common fund, from which physicians' and hospital bills are paid monthly.

No plans are begun in a State without obtaining first the approval of the State Medical Association, and second, the active cooperation of the county medical societies. Farm families on the rehabilitation program are then informed

that they may participate in the plan on a prepayment basis at a cost which averages from $15.00 to $30.00 a year per family. For this sum, which represents the maximum that families netting an income of from $20 to $300 can afford to pay, they are assured of physicians' services for emergency medical care, ordinary drugs, obstetrical care, limited emergency surgical and hospital care, and sometimes dental care.

Medical care plans, which first operated in only a few counties in several states, are now serving more than 80,000 families in 33 states. Such an expansion was possible only because a need which had gone begging was at last recognized.

The emergency nature of acute illness has claimed first attention in the development of medical care plans for Farm Security Administration borrowers and their families. With the group medical care program working satisfactorily, however, we have turned our attention to the less pressing but more tenacious problem of chronic disease. In an effort to determine how many borrower families are burdened with disease not of an emergency nature, examinations of rehabilitation families in sample counties have been completed in each of 18 states.

The results of these examinations have not yet been completely tabulated or analyzed, but preliminary findings show an impressive percentage of conditions that are now retarding or preventing rehabilitation. Many of these conditions directly influencing health and rehabilitation can be corrected at small cost, such as faulty diet, poor nutrition, and insanitary conditions. If these are given attention future serious illnesses may be prevented. Other retarding conditions such as infected tonsils, hernias, and the results of childbirth injuries can be corrected by surgical operations. Unfortunately, a certain small percentage of rehabilitation families can not possibly improve their status because of health conditions that have been neglected over too long a period of time.

On the whole, however, we find that most of the farm families with whom we are working are capable of satisfactory farming, if we can teach them to use their ability in the most effective way. This is borne out by the report of a psychiatrist who conducted examinations for a group of rehabilitation families in a Western State. But he also goes on to say that, "In every instance the outstanding feature was the pall of gloom which colors the outlook of all these folks. The same story was told time after time -- years of crop failure, absence of moisture, grain burning up in the ground, increasing debt burden. The wonder is that there are not more personality disturbances. In this connection, it is of interest that the percentages of presumably functional complaints are so much higher in the groups of heads of families and their wives than in the other and younger members of the group; as each year produces its toll of discouragement, one's supply of optimism and resilience diminishes."

By achieving some success through the rehabilitation program, the gloomy outlook of these farm families can be eliminated. The Farm Security Administration has gone a long way, however, towards making possible the success of farm families by realizing that physical rehabilitation is an important factor in economic rehabilitation.

Since the unleashing of war in Europe, the implications of our medical program reach far beyond putting rehabilitation families on a stable basis to repay their loans. The physician who examined male members of rehabilitation families 15 years of age and over in a typical rural county found only five per cent to be excellent physical specimens. Nearly 20 per cent showed physical defects or disease which definitely hindered their welfare. There is an encouraging note, however, in his findings that in at least 90 per cent of these persons, their defects are correctible.

The health of our rural population is inseparable from the health of our defense forces. Rural areas regularly contribute more recruits in proportion to their population than cities and large towns. From January through June, 1940, for every 37 recruits volunteering per 100,000 population in cities, ten rural states recruited 80 men per 100,000 -- more than twice as many. Although Americans are supposedly healthier than ever, army medical officers are finding nearly one out of every three volunteers unfit for military service because of physical defects or impaired health. (The physical fitness not only of our military men, but also of our civilian population will determine the effectiveness of our defense efforts. The health of the nation depends upon the health of the individuals who comprise that nation.)

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MEDICAL CARE PROGRAMS SPONSORED BY THE FARM SECURITY ADMINISTRATION

By: R. C. Williams, M. D.
Chief Medical Officer
Farm Security Administration

(Printed in the July, 1940 issue of the Journal of the Medical Society of New Jersey. Reprinted with permission of The Medical Society of New Jersey.)

Close cooperation with the organized medical profession is the keystone of the policy of the Farm Security Administration in coping with the health problems of low-income farm families. Successful working agreements are already in effect between the Farm Security Administration and thirty-eight State Medical Associations; and health programs are conducted in over five hundred counties in thirty-one states; and approximately 80,000 medically indigent families are receiving medical services. In addition, several hundred thousand farmers are receiving advice and instruction regarding poor farm practices, depleted soil, meager equipment, inadequate diets, unsanitary conditions, and lack of marketing facilities -- all of which affect health, as well as economic conditions.

The rehabilitation program is fundamentally a self-help program, as distinguished from direct relief. Loans are made which must be repaid to the Federal Government. Before a loan is approved, a detailed farm and home management plan is prepared by the farmer and his wife, with the help of the local rehabilitation supervisors. Continuous help and advice are extended by agricultural and home management experts during the life of the loan, to the end that intelligent planning and a sense of responsibility may lead to economic rehabilitation and self-sufficiency.

The Farm Security Administration is not placing undue emphasis on medical care plans to the exclusion of other significant factors related to rural health. The basic program is one of economic rehabilitation. Self-sufficiency would minimize the medical care problem for many families. Education in dietetics, sanitation, and the intelligent utilization of the services of modern medicine and public health, contribute to solving the problem of medical care.

The Administration recognizes the fact that good health is fundamental in economic rehabilitation. The failure of many farmers is the result of inability to do a good day's work; and failure to meet loans on schedule has often been due to illness, or to the expenditure of the family's limited funds to meet urgent medical bills. The unpredictability of sickness is a factor which has often nullified carefully worked-out plans of rehabilitation.

With this condition as a background, the Farm Security Administration has cooperated with the medical profession in spreading the cost of illness

over an entire group of these families in a county or district. Each Farm Security Administration borrower budgets a certain amount for medical care expenses; in other words, the borrowers as a group take out a kind of voluntary insurance against the bankruptcy which might result from serious illness. The participating physicians receive prompt, if not always full, payment for services to families who in the past have been able to pay little or nothing.

The program in effect in Atlantic County since March 15, 1939 -- the first such plan in New Jersey -- will serve as an example of existing plans. However, its provisions are limited to general practitioner care, whereas most plans also include emergency hospitalization, specialist care, and prescribed drugs. The Atlantic County Medical Society supervises the program, acting through a committee of three physicians. A bank official in May's Landing acts as Trustee of the fund into which families pay in advance annual dues ranging from $16 to $20, assisted by loans in most cases. Monthly bills, submitted to the Trustee and reviewed by the committee of physicians, are paid from monthly allotments, being subject to proportionate reduction if the funds available do not provide full payment.

During its first year this medical service plan provided 83 families with an average of 3.16 office and home calls per person, and paid 100 per cent of the bills submitted in accordance with the comparatively low fee schedule adopted by the Medical Society. Abuse of privileges was limited to one family, and was easily controlled.

In accordance with its policy of collaboration with the medical profession and its medical service organizations, the Farm Security Administration has requested The Medical Service Administration of New Jersey to administer a program which would be extended to approximately 1,000 rehabilitation borrowers in rural counties throughout the State, after their acceptance by the several county medical societies. It is expected that such a program will soon be drawn up. Like that in Atlantic County, it would be based on free choice of physician, local medical supervision, and the ability of the families to pay.

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U. S. Department of Agriculture
Farm Security Administration
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